

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS APR 26 1960

-60-015198

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2020 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. <input checked="" type="checkbox"/> institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in lb <u>18 1/2 days</u>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Luke's Hospital</u>				d. STREET ADDRESS (If outside, give location) <u>Montrose Hotel</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>G.</u> Last <u>Campbell</u>			4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>1960</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>12-19-1848</u>	9. AGE (last birthday) <u>91</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>NEWBERG, INDIANA</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
13a. FATHER'S NAME <u>STOKES GARWOOD</u>			13b. MOTHER'S MAIDEN NAME <u>LAURA LYNCH</u>		14. NAME OF HUSBAND OR WIFE <u>JAMES P. CAMPBELL</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MRS. H. G. STERNBERG ST. LOUIS, MO.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral encephalomalacia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) <u>cerebral thrombosis, left side</u> <u>2 days</u>	
DUE TO (c) <u>cerebral arteriosclerosis</u>						P	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>benign hypertension</u>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>Nov 1959</u> to <u>April 1960</u> and last saw her/him alive on <u>April 11, 1960</u> Death occurred at <u>8:50 A.M.</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Arthur Gene Petersen M.D.</u>			22b. ADDRESS <u>411 Nichols Road, K.C. Mo</u>		22c. DATE SIGNED <u>4-11-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>4-12-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>OLD MISSION MAUSOLEUM</u>		23d. LOCATION (City, town, or county) (State) <u>WICHITA, KANSAS</u>			
24. FUNERAL DIRECTOR <u>FREEMAN MORTUARY K.C. MO.</u>		ADDRESS		25. DATE RECD. BY LOCAL REG. <u>4-11-60</u>	26. REGISTRAR'S SIGNATURE <u>Neva Minahall</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Arthur Gene Petersen

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed 

Licensed Embalmer No. 293
P. O. Address F. O.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.